Issue 1 April 2002

network

SMMGP
SUBSTANCE MISUSE MANAGEMENT IN GENERAL PRACTICE

A national newsletter on substance misuse management in primary care

Newsletter Re-launch

Network

SMMGP Re-launch

Network is our new newsletter name and the new face of the SMMGP project. For those who are not tongue twisters by nature, most project staff included, it comes none too early. Acronyms exhausted, the name arises from our other known identity as the Primary Care Network and the function we feel best describes our core mission, our way of working and our new partnership arrangements.

IN THIS ISSUE

www.smmgp.co.uk

What's NEW about Network?

- New name and layout
- Easy read format
- Increased clinical content
- Hot topics to keep you abreast of what's going on
- Paper, article and classic book reviews
- A regular alcohol feature

Network Partnerships

- **The National Treatment Agency (NTA)** will provide representation on the SMMGP Project Advisory Group, will act as fund holder and may become staff employer for the project. Line management will be through Don Lavoie as NTA Commissioning Manager. London based office space will be available to the team to conduct joint NTA work. Project staff will support the primary care related work of the NTA.

- **The Royal College of General Practitioners (RCGP)** will continue to provide representation on the SMMGP Project Advisory Group and advisory editorial input from Dr Claire Gerada and Dr Chris Ford. The RCGP will also make available London based office facilities for project staff carrying our joint work. Project staff will support the RCGP Certificate programme and other RCGP development work.

- **Trafford Healthcare NHS Trust** will host the project with project supervision provided by Mike Smith, Clinical Manager of Trafford Substance Misuse Services. GP Facilitation will be provided to the project by Dr Chris Ford.

We feel it is a fitting role for the project to bridge the work of GPs, other primary care staff working in the field and specialist services with the national policy and development work of the RCGP and the NTA

PRESCRIPTION

FP10

- Join our free mailing list
- Visit our interactive web site and virtual offices www.smmgp.co.uk

- If you have a clinical question put it on the on-line surgery
- Download our on-line RCGP Certificate materials
- Come to the RCGP national conference Managing Drug Users in General Practice, It's Not Just About Prescribing on the 9th&10th May. Contact the RCGP conference organiser on 020 7823 9703 or email pelliott@rcgp.org.uk
- Phone NETWORK on 0161 905 1544

Young People
Determining consent for drug treatment to minors

General Practitioners are often the first point of contact for distressed parents when they discover that their child is using drugs, but finding a solution to this problem is not an easy one for any GP.

The Clinical Guidelines recommend that any drug user should be fully assessed prior to an intervention. When working with young people, those under 18, it is also recommended that GPs work in conjunction with specialist drug services. However, when all this is said and done it is often the GP who is called upon to consider any prescribing intervention and here the contentious issue of consent to treatment raises its head.

As any GP is aware any treatment requires consent, but most patients are over 16 and able to consent themselves, or else their parent has brought them to see you and consents on their behalf. For drug users though there may be difficulties at home, or they may not live at home any more, and may arrive without a parent or parental responsibility holder to consent for them. This then leaves the GP to decide whether they are 'Gillick' competent, as it is only the person delivering the intervention that can make the final decision.

Using 'Gillick' competence benchmarks to decide if someone is able to consent to their own drug treatment has been shrouded with some mystery. This is because while legal representation assures us that it should be applicable outside of contraception advice and treatment, this has not actually been tested in court and so there remains some uncertainty. The Children Act 1989 has within it the principles of 'Gillick' competence, in that we should all act to ensure the best welfare of a child. But this still leaves some unease as prescribing for adult drug users is contentious to some GPs let alone prescribing to minors.

The Fraser guidelines did fortunately shed some more light on this issue, referring directly to providing medical treatment for substance misuse, though their existence has not been well published. GPs should still bear in mind that their assessment against these guidelines is crucial and that the Clinical Guidelines recommend that they should not act without the support of a specialist service.

Fraser Guidelines
(Mental Health Act 1983, Code of Practice 1999)

A young person under 16 years of age has the right to confidential medical advice and treatment provided that:

- S/he understands the advice and has the maturity to understand what is involved;
- the doctor/health professional cannot persuade the young person to inform the person who holds parental responsibility nor allow the doctor to inform that person;
- the young person's physical and/or mental health will suffer if they do not have treatment;
- it is in the young person's best interests to give such advice/treatment without parental consent;
- in the case of contraception or substance misuse, the young person will continue to put themselves at risk of harm if they do not have advice/treatment.

Jill Britton DrugScope

>> DrugScope at www.drugscope.org.uk – A leading UK centre of expertise on illegal drugs. Website offers a library, news, information, policy advice and links.

The Audit Commission Report February 2002

This excellent report emphasises the positive role GPs play in treating drug users. It also highlights the need for GP payments, training and monitoring together with local guidelines clarifying roles of GPs and specialist services. Effective support to GPs from specialist services is also stressed as crucial.

See full report on www.audit-commission.gov.uk or tel. 0207 828 1212

Alcohol

The AUDIT – Alcohol Use Disorder Identification Test

The GP and wider primary health care team can be key to identifying and treating alcohol problems. But in practice we are poor at identifying problems that may be related to heavy alcohol use.

Patients can present with an enormous variety of conditions ranging from hypertension, gastrointestinal problems, anxiety and depression. Although not all patients with drinking problems are dependent on alcohol, there is a high prevalence of alcohol problems in the general population. Screening all patients for potential alcohol misuse will reveal a much higher number of patients with alcohol or potential alcohol problems than going by presenting conditions alone. Asking about drinking patterns should become part of most consultations.

The AUDIT (Alcohol Use Disorder Identification Test) has been validated by WHO with high sensitivity and specificity. It can be self completed or administered in 2-4 minutes. A score of 4 or below indicates no further action. Scores need to be checked periodically, possibly annually.

A score of 5 or above suggests a risk of developing a problem, and that more interventions are required. Primary care staff can use brief interventions, full assessment of alcohol intake and clear advice. A score of +/- 10 suggests a dependent drinker for whom brief interventions are not suitable. Consider community detoxification or refer to specialist services.

AUDIT - This is a new validated screening tool. It is quick to use and simple to understand which makes it ideal for use in primary care settings. We will follow up next issue with primary care based interventions. Feedback on this tool welcomed.

>> **Alcohol Concern at www.alcoholconcern.org.uk**
British organization devoted to reducing alcoholism. Site includes a news summary, fact sheets and related links. This site allows users to search its library database and services directory and to order publications from their on-line bookshop.

>> **The Medical Council on Alcohol at www.medicouncilalcol.demon.co.uk**
This organisation on Alcohol is a charity concerned with the education of the medical and allied professions about the effects of alcohol upon health.

Alcohol Screening

Questions	Score 0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7or 8	10 or more
How often during the last year have you found that you were not able to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Has a close relative or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

A GP's reflections on the value of long-term methadone prescribing/methadone maintenance

Dr Jez Thompson

Long-term methadone substitution therapy for opioid-dependent people has been around since the 1960s. The stated aims of such treatment have been to improve the physical, psychological and social well-being of the prescribee, as well as to address social issues such as disease transmission and drug-related crime. Methadone maintenance is now one of the most evidence-based treatments in addiction today although most of this research has been done in countries other than the UK (mostly in the US and Australia). We in the UK may not have got methadone maintenance quite right as yet (see NTORS paper review in previous SMMGP Newsletter No. 21).

However, there is a substantial body of evidence indicating that these stated aims really can be achieved in a methadone programme. Methadone maintenance prescribing may be seen as a lifetime strategy to reduce harm, or is seen as a medium to long-term, but interim, step towards the goals of reduction, detoxification and abstinence. Its value as a treatment option however is clear.

Areas of benefit include:

Reduction in morbidity and mortality. Most of us who prescribe methadone will be able anecdotally to identify positive improvements in our clients' well-being once a programme is started, in the way they look, behave and dress. Though some aspects of general physical health may be difficult to quantify in studies, methadone maintenance has well-documented positive effects on physical well-being. These effects range from weight gain through to the re-establishment of normal menstrual cycles and improved immunological function in opioid users. In addition there is incontrovertible evidence that carefully managed methadone maintenance schemes greatly reduce the risk of death from opioid overdose.

Reduced psychological morbidity and improved quality of life. There is a high prevalence of both psychological distress and morbidity in opioid users. Treatment with methadone has been shown to significantly reduce test scores of psychological distress. Studies have also shown improved social functioning in areas such as family relationships, social stability and financial stability.

Decreased transmission of HIV. Studies show that methadone prescribing for opioid users (particularly with higher doses and longer term treatment) leads to lower illicit drug use and decreased injecting-related risk behaviour, and therefore reduced exposure to HIV. A further potential benefit in reducing infection with hepatitis B and C has not been clearly demonstrated.

Engagement in treatment. Methadone maintenance programmes have been shown to be effective in engaging drug users in long-term treatment. This allows for repeated input in terms of health promotion and harm reduction advice.

Reduction in crime. A drug habit brings with it the need to raise regular and large sums of money, and may in itself predispose to risky and anti-social behaviour. Current estimates in the UK suggest that up to 70% of crime is drug-related. There is convincing evidence that crime is reduced when opioid-dependent users are prescribed regular methadone, again particularly with higher doses (>60mg/day) and longer-term treatment.

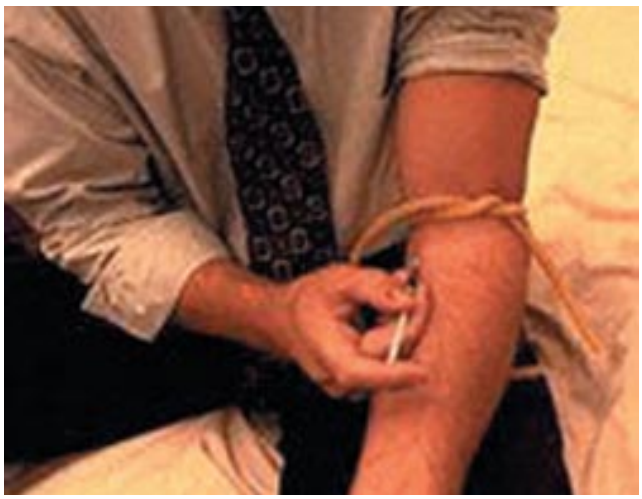
Established cost effectiveness. Methadone is the most researched and most frequently used form of substitution therapy. The reductions in mortality, morbidity and crime associated with treatment intervention make it cost-effective. Rates of retention in treatment and outcomes across a variety of domains compare favourably with alternative prescription drugs.

Dr Jez Thompson, St Martins Practice, 319 Chapeltown Rd, Leeds LS7 3 JT

A GP's reflections on the value of detoxification from opiates

Dr Nat Wright

Having worked with the homeless population of Leeds for six years, it never ceases to amaze me how many homeless people request detoxification from opiates. Behind their request is a desire to become drug-free and start a process of rehabilitation away from homelessness. Many homeless people use large amounts of heroin, inject into unsafe areas and are without the support of friends or family. Very few of them have any meaningful employment or leisure activities. They are the client group par excellence for a



harm minimisation approach of long-term opiate substitute prescribing. Indeed this is our approach for many, if not the majority, of our patients. However, our training as general practitioners has encouraged us to take an eclectic, inclusive approach to health-care. Adopting such an approach helps us work with patients who request detoxification. For some, they are at a stage where they are ready to move away from heroin use. Others are about to serve a custodial sentence and wish to be free from opiates before going to prison. Others are not sure whether they are able to remain abstinent from opiates but at least wish to give it a try. Sometimes they are less concerned about relapse back into dependence than we are!

Let us consider what might be the appropriate situation and setting to offer opiate detoxification. Seivewright[i] notes that patients with the following features are desirable for quick community detoxification from heroin

- Short history
- Low level of use
- Not injecting
- No significant current or other drug use
- Good motivation
- Absence of personality disorder
- Supportive family member(s) or partner to be involved

Despite the widespread practice of detoxification, the evidence base is sparse both for what the ideal circumstances are and which is the ideal agent to use. The Department of Health Clinical Guidelines[ii] suggest that the following agents may be useful in achieving successful detoxification

- Methadone
- Dihydrocodeine
- Buprenorphine
- Lofexidine
- Clonidine
- Naltrexone

The guidelines suggest that naltrexone treatment should be carried out by "specialists with inpatient facilities". They also point out that treatment with clonidine can lead to a marked hypotensive effect. Other commentators point out that methadone prescribed as an agent for withdrawal is less than ideal. This is because of its long half-life causing protracted withdrawal symptoms. Accepting the limitations of these treatments, leaves the options of buprenorphine or dihydrocodeine. Recently, a Cochrane review of all the clinical trials that evaluated the use of buprenorphine for the management of opioid withdrawal was published[iii]. The review found that worldwide there was a total of five published trials. Four of these studies compared buprenorphine with clonidine. The other described numbers of subjects who completed a 10 day buprenorphine withdrawal regime. The Review concluded that buprenorphine "had potential" as an approach to manage withdrawal from heroin but "the small number of studies, the extent of variability in those studies, and the risk of bias in two of the studies... make it impossible to draw any conclusions as to appropriate treatment protocols or likely outcomes from the use of buprenorphine to ameliorate signs and symptoms of opioid withdrawal". A study to explore treatment protocols and likely outcomes is much needed by the field. (See Bulletin on page 8)

Ed: A 2001 issue of Drug and Alcohol Dependence had a study published which makes a good start at comparing buprenorphine (Subutex) and lofexidine.

White, R; Alcorn, R & Feinmann, C. Two methods of community detoxification from opiates: an open-label comparison of lofexidine and buprenorphine. Drug and Alcohol Dependence 65 [2001] 77-83

[i] Seivewright Nicholas. Community treatment of drug misuse: more than methadone. Cambridge: Cambridge University Press, 2000. (Studies in social and community psychiatry).

[ii] Department of Health (1999) Drug Misuse and Dependence — Guidelines on Clinical Management. London: HMSO.

[iii] Gowling L, Ali R and White J. Buprenorphine for the management of opioid withdrawal (Cochrane Review). In The Cochrane Library, Issue 3, 2001. Oxford

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Classics revisited

The Methadone Briefing

Written and edited by Andrew Preston with many contributing authors. Last edition 1996.

This is a book I use over and over. It is clear, easy to use and full of useful information that we often need when prescribing methadone to opiate dependent patients. It is also a valuable guide for those just starting this work and covers a range of key areas, including assessment, interactions and how to do maintenance and detoxification.

I particularly like the section on 'physiology and pharmacology of methadone', which explains this in a way that I can understand. The section on 'treatment aims and treatment choices' is very balanced and it really helps us to think about what we are providing and why.

It is strongly evidence based and provides a good foundation for good practice. As things are currently changing, particularly around the law and alternatives to methadone, it would really benefit from an update. Nevertheless it is still one of the classics - definitely one not to be missed!

Do you have a classic that you use and would you like to share it with us in the next edition?
Chris Ford

Review of recent papers, articles and reports

1.Oliver P., Keen J. and Mathers N. Deaths from drugs of abuse in Sheffield 1997-1999: what are the implications for GPs prescribing to heroin addicts? Family Practice Vol. 19, No. 1, 93-94 Oxford University Press 2002

The objective of this paper was to look at the role of increased methadone prescribing in Sheffield between 1997-1999 on drug related deaths. All deaths reported to coroners were looked at during this 3-year period. Eighty-two drug of abuse-related deaths occurred and the majority were in single (89%), unemployed (84%), men (92%) with a mean age of 29.4 years. Heroin on its own or in combination with other drugs was considered to be responsible for 70% of the deaths. Deaths attributable either wholly or partially to methadone poisoning fell from 37% in 1997 to 18% in 1999 at a time when prescribing of methadone increased. Where heroin or methadone was implicated alongside another drug, the most common were benzodiazepines and alcohol. It appears that the availability of methadone was not a factor involved in the increase in the number of drug related deaths in this study.

2. Drug related deaths as reported by coroners in England and Wales. Annual Review 2000 published October 2001 np-SAD, St Georges Hospital

The report covering 1300 drug related deaths in England in 2000 shows a significant fall in methadone related deaths but a significant rise in heroin related deaths – see 'Hot Topics' p.8 for the government's action plan to combat this rise.

3. Jaeckel E. et al Treatment of Acute Hepatitis C with Interferon Alfa-2b The New England Journal of Medicine Volume 345: 1452-1457 November 15 2001 Number 20

Chronic infection in people who are infected with the hepatitis C virus often develops and is difficult to eradicate. This study undertaken in Germany shows that treatment with interferon alfa used subcutaneously daily for 4 weeks and then 3 times / week for another 20 weeks during the acute phase could prevent the development of chronic infection. 98% of patients after treatment had undetectable levels of HCV RNA in serum and normal serum alanine aminotransferase levels and the treatment was well tolerated.

4. Reneman L et al Effects of dose, sex and long-term abstention from use on toxic effects of MDMA (ecstasy) on brain serotonin neurons Lancet 2001; 358: 1864-69

This small study indicated that heavy use of ecstasy was associated with neurotoxic effects on serotonin neurons. It showed that women might be more susceptible than men and that MDMA-induced neurotoxic changes in several brain regions of female ex-MDMA users are reversible. The study could not rule out the possibility that the neurotoxic effects might be long-lasting or only partially reversible in the parieto-occipital cortex and occipital cortex.

Dr Fixit on Methadone & Palliative Care

One of our specialist GPs who works at a local agency also works in the Macmillan Unit and so is experienced at prescribing in terminal care. He says that in palliative care methadone is always used twice a day. He also says that recently he has had more people coming to the agency saying they can't sleep and as a result are very tempted to use heroin on top of their methadone. Is there any argument for taking the dose of methadone in two aliquots? Why are doses split in palliative care and is there any reasonable rationale for splitting doses in treatment or opiate addiction?

Answer by Dr Kay Roberts, Area Pharmacy Specialist–Drug Misuse, Glasgow

The reason methadone is used twice a day in palliative care is that for pain two or three times a day is necessary as the pain relieving properties of methadone are not the same as the withdrawal prevention properties (every eight hours is common for pain). However, for some patients twice a day may be necessary for the latter use, particularly if the patient is a fast metaboliser of methadone or there is a CYP2D6 interaction that increases the metabolism of methadone. As afar as sleep is concerned, sometimes if methadone is given later in the day it can overcome the "wakefulness" towards the end of the dosing period. On the other hand, night sweats are a side effect of methadone and these can keep people awake. Good "sleep hygiene advice" can sometimes be helpful as well.

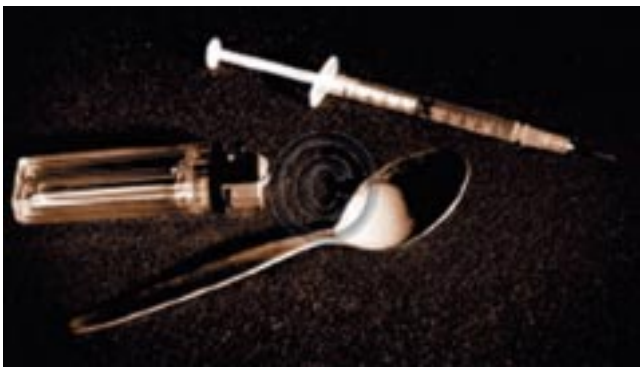
Ed – Dose splitting in terms of withdrawal prevention may primarily be an issue of patient choice. There is no need for GPs to become involved in splitting prescribed doses in opiate addiction as this is impractical in terms of community dispensing. However, GPs need to be aware that many patients choose to self medicate in this way. It can be an issue in terms of supervised consumption schemes where dispensing happens once daily. Where a patient prefers to split their dose, attendance at a pharmacy twice daily may be unrealistic.

Dr Fixit on Hepatitis C

I have found that several of the drug users I have been managing in primary care are positive for hepatitis C. I have been monitoring their liver function tests (LFTs), which at the moment are all normal. Should I do more and what other advice should I be giving them?

Answer Dr Chris Ford

Hepatitis C is one of the viruses that can cause liver disease; it can lead to years of morbidity and can be fatal. Chronic hepatitis C has a complex natural course that is difficult to



predict in an individual. It can lead to cirrhosis of the liver for some patients and death from liver failure or primary liver cancer in a few. In order to establish current infection, a test for HCV-RNA using Polymerase Chain Reaction (PCR) must be carried out. PCR tests are not usually carried out until the patient is seen by a specialist, usually a hepatologist or gastroenterologist. Acute hepatitis C does not usually cause a clinically apparent illness and symptoms are likely to be limited to a mild illness that can be mistaken for 'flu type' virus or drug withdrawal. The major clinical significance is chronic infection that is likely in 80-85% of cases. Numerous studies have attempted to determine predictors of disease progression to cirrhosis. These studies indicate that some factors such as duration of infection, age, gender, heavy alcohol consumption, co-infection with HIV or hepatitis B are relevant to disease progression but to what degree is still unclear. It is also likely that the viral load and possibly the genotype of the virus have a role to play but this is less clear. There are several strains of the virus that differ genetically from each other but can all be classified as hepatitis C virus. Some studies indicate that men are more likely to progress to cirrhosis than women but it is not clear if other factors have influenced this trend. Most people becoming infected with hepatitis C will be unaware of it at the time. Many people who go on to be chronically infected with hepatitis C will have no symptoms while others will feel unwell to varying degrees.

The most commonly reported symptoms are: Mild to severe fatigue; anxiety; weight loss; loss of appetite; alcohol intolerance; pain or discomfort in the area of the liver; concentration problems; nausea; fever; muscle aches and jaundice (although this is rare). It should be noted that the degree of symptoms the patient experiences does not necessarily indicate the extent of liver damage. Some patients will report quite severe symptoms with no clinical signs of liver disease while cirrhosis can be present without any obvious symptoms. You cannot develop natural immunity to hepatitis C and no vaccination exists. All patients should be offered hepatitis A and B vaccination. Evaluation of the disease will normally be undertaken by specialist centres that will first establish the presence of current infection by PCR test for HCV-RNA. Where current infection is noted, more sophisticated PCR tests can identify the predominant viral genotype (1, 2, 3, 4, 5 or 6) and the viral load . An ultrasound scan will also be undertaken and the patient offered liver biopsy to measure the degree, if any, of fibrosis or cirrhosis. However, not all tests are routinely available. It should be remembered that LFTs are not an accurate predictor of disease progression. The only accurate way to measure the degree to which the liver is affected by the virus is to carry out a liver biopsy that will be done in the specialist centre.

The National Institute for Clinical Excellence (NICE) recommended (Final Appraisal Document, 31 October 2000) combination therapy of interferon and ribavirin in the treatment of hepatitis C for patients not previously treated or who have relapsed following treatment. This treatment is by 3 x weekly self-subcutaneous injection of interferon alfa and daily dosage of oral ribavirin. This treatment has a favourable response in about 55% of patients. Favourable response is described as the patient remaining PCR negative six months after treatment has stopped. The newer slow release pegylated interferon that maintains therapeutic drug levels over a longer period and is administered only once weekly is being trialled at present.

NICE does not recommend treatment for:

- Anyone continuing to inject drugs where drug interactions, compliance and the possibility of re-infection are issues

Ed: This should not be interpreted to mean that all current injectors should be excluded from treatment

- People who continue to drink heavily
- Non-responders to interferon monotherapy
- Those with decompensated cirrhosis

Hepatitis C guidance for those working with drug users

The most important advice for patients is to **stop or reduce alcohol consumption.**

So don't forget:

- Advice about alcohol and healthy diet.
- Recommend stopping injecting of all street drugs
- If going to continue injecting, recommend all clean equipment (including spoons and filters) and NO SHARING
- Vaccinate against hepatitis A and B.
- Refer to a specialist (after informed consent) for PCR to test for active infection and liver biopsy for staging of the disease (LFTs are not a good indicator of the damage to the liver). The need for treatment will be decided on the results of the biopsy

See DOH ***Hepatitis C guidance for those working with Drug Users*** at www.doh.gov.uk

Hepatitis C briefing paper – essential information for professionals will be delivered to all surgeries soon or available on www.doh.gov.uk/hepatitisc

Research Bulletin

International review of literature

Review relating to the following management options for opiate dependent individuals: Residential Rehabilitation; Community Detoxification; Community Maintenance

We aim to identify the demographic and programme factors that influence treatment outcomes, to consider the cost effectiveness of these treatments and to highlight gaps in the existing research evidence. We would be particularly interested to hear from anyone who has recently completed or are currently conducting research in any of the above areas.

Karen Inkster, Dr C Matherson, and Professor C Bond can be contacted at the Department of General Practice and Primary Care, Foresterhill Health Centre, Westburn Road, Aberdeen AB25 2AY, Scotland, Telephone 01224 4036 25/01224 552636, Fax 01224 840 683, gppc@aberdeen.ac.uk

Dihydrocodeine verses buprenorphine in primary care study

It is surprising, in fact astounding, is that there have not been any published randomised control trials which evaluate the effectiveness of dihydrocodeine as a treatment for detoxification from heroin. This is despite its wide use, with anecdotal reports of being a useful agent when used in an appropriate context. Upon realising this six months ago, I decided that it was time that primary care looked at contributing to the developing evidence base in this area. In collaboration with the Institute of Psychiatry, Leeds University, and with other primary care service providers in the city, we have devised a research protocol, which will specifically evaluate the effectiveness of dihydrocodeine versus buprenorphine, when given in the primary care setting for the treatment of opiate withdrawal. Watch this space, we hope that it will lead to evidence by primary care for primary care and go a long way to answering the question of "when our patients request detoxification, which treatment has the best chance of achieving abstinence?" Dr Nat Wright NFA Health Centre for Homeless People, 68 York Street, Leeds, LS9 8AA 0113 295 4840 Leedsproject@hotmail.com

Mothers' drug use and infant development

Researchers in the University of East London Psychology dept are starting a 5 year research project investigating whether or not mothers' use of recreational drugs during pregnancy has effects on infant neurobiological development or mother-child interactions. They would be interested in help with recruitment. Please contact Julia Goodwin 020 8223 4587 or j.e.goodwin@uel.ac.uk

Hot Topics

Government launches plan to reduce drug-related deaths

The Department of Health launched its action plan to prevent drug-related deaths in late November 2001.

The Office of National Statistics reported that 1568 people died of accidental overdose involving illegal drugs in England and Wales in 1999. Although more research is needed, promoting practical measures such as first aid training for drug users and harm reduction training for drug treatment staff could have prevented many of these deaths. The action plan covers three strands over the next 3-5 years: 1.Campaigns including staff training; 2.Better surveillance and monitoring to increase analysis of information from coroners reports; 3.Research. More information from the Department's web-site www.doh.gov.uk/drugs.

UK still tops the drug league: EMCCDDA Annual Report

This European report still shows the UK having the highest level of drug use across a whole range of drugs:

1. Rising heroin use, opposite to other European countries.
2. Double the rate of ecstasy and amphetamine use amongst adults.
3. Slight increase of use across the range of drugs in young people.
4. The highest use of cannabis (with France) amongst 15-16 year olds

Full annual report can be found at www.emcdda.org

NETWORK Production

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NETWORK NEWSLETTER IS SPONSORED BY SCHERING-PLOUGH LTD

Network ISSN 1476-6302

SMMGP works in partnership with

1952-2002 Trafford Substance Misuse Services

NHS National Treatment Agency for Substance Misuse

SMMGP is funded by the Treasury, Invest to Save Budget

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